FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041889

Facility Name: CARE CENTRE OF CHAMPAIGN

Address: 1915 SOUTH MATTIS STREET (Number) CHAMPAIGN (City) 61821 (Zip Code)

County: CHAMPAIGN

Telephone Number: (847) 674-4700 **Fax #** (847) 674-4733

IDPA ID Number: 36-4082499

Date of Initial License for Current Owners: 06/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DON FIETS **Telephone Number:** (847) 674-4700 X40

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) BRADLEY ALTER

(Title) SECRETARY

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	118	Skilled (SNF)	118	43,070	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,070	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,707	1,707	8
9	SNF/PED					9
10	ICF	20,578	2,770	1,136	24,484	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,578	2,770	2,843	26,191	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.81%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 1,707

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	130,849	8,342	5,858	145,049		145,049		145,049			1
2	Food Purchase		120,568		120,568		120,568	(268)	120,300			2
3	Housekeeping	74,772	17,071		91,843		91,843		91,843			3
4	Laundry	42,149	12,194	732	55,075		55,075		55,075			4
5	Heat and Other Utilities			81,362	81,362		81,362	476	81,838			5
6	Maintenance	32,531	13,955	16,057	62,543		62,543	312	62,855			6
7	Other (specify):*			6,011	6,011		6,011		6,011			7
8	**TOTAL General Services**	280,301	172,130	110,020	562,451		562,451	520	562,971			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	862,507	76,175	245,826	1,184,508		1,184,508	19,605	1,204,113			10
10a	Therapy	18,066	1,717	90	19,873		19,873		19,873			10a
11	Activities	42,445	2,762	3,423	48,630		48,630		48,630			11
12	Social Services	22,037		2,623	24,660		24,660		24,660			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	945,055	80,654	260,962	1,286,671		1,286,671	19,605	1,306,276			16
	C. General Administration											
17	Administrative	93,797		23,911	117,708		117,708	3,221	120,929			17
18	Directors Fees											18
19	Professional Services			98,498	98,498		98,498	(72,523)	25,975			19
20	Dues, Fees, Subscriptions & Promotions			12,943	12,943		12,943	(5,358)	7,585			20
21	Clerical & General Office Expenses	40,044	11,462	132,210	183,716		183,716	(42,380)	141,336			21
22	Employee Benefits & Payroll Taxes			284,840	284,840		284,840	9,751	294,591			22
23	Inservice Training & Education											23
24	Travel and Seminar			640	640		640	6,737	7,377			24
25	Other Admin. Staff Transportation			1,475	1,475		1,475	6,172	7,647			25
26	Insurance-Prop.Liab.Malpractice			109,350	109,350		109,350	10,376	119,726			26
27	Other (specify):* MARKETING	27,519			27,519		27,519	(27,519)				27
28	**TOTAL General Administration**	161,360	11,462	663,867	836,689		836,689	(111,523)	725,166			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,386,716	264,246	1,034,849	2,685,811		2,685,811	(91,398)	2,594,413			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: CARE CENTRE OF CHAMPAIGN #0041889 **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,858	
	REPAIRS & MAINTENANCE		0	
			0	5,858
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		732	
			0	732
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		25,318	
	ELECTRICITY		30,681	
	WATER		25,363	
	CABLE TV - LOBBY		0	
			0	81,362
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,839	
	PAINTING & DECORATING		130	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		5,161	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,235	
	FIRE SERVICE		4,692	
			0	
			0	
			0	16,057
7	**OTHER**			
	SCAVENGER		6,011	
	SECURITY SERVICE		0	6,011
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	9,000	9,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	232,689	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		10,585	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	527	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,025	
	PHARMACY CONSULTANT	XVIII B 39-2	0	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	245,826
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	19	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	29	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	42	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	90
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		1,823	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,600	
			0	3,423
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,623	
			0	2,623
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN #0041889 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	23,911	23,911
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	6,314	
	ADMINISTRATIVE CONSULTANTS	XIX C	47,748	
	PROFESSIONAL FEES	XIX C	44,436	
			0	98,498
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	3,673	
	EMPLOYEE WANT ADS	XIX F	4,080	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	448	
	LICENSES & PERMITS	XIX F	3,010	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,732	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	12,943
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		191	
	OUTSIDE CLERICAL SERVICES		107,496	
	PENALTIES / OVERDRAFT CHARGES	VI 18	12,838	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		238	
	TELEPHONE		8,373	
	MESSENGER SERVICE/POSTAGE		3,074	
			0	132,210

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	105,098	
	UNEMPLOYMENT COMPENSATION	XIX D	54,175	
	WORKERS COMPENSATION INSURANCI	XIX D	65,542	
	HOSPITALIZATION INSURANCE	XIX D	56,054	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,618	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	2,353	
	CHICAGO HEAD TAX	XIX D	0	284,840
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	509	
	TRAVEL	XIX G	131	
			0	
			0	640
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		1,475	1,475
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		109,350	109,350
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 1,034,849

CARE CENTRE OF CHAMPAIGN
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	120,568	PATIENT MEALS	78573
LESS SALES TAX	(268)	ADD EMPLOYEE MEALS	0
NET FOOD	120,300	TOTAL MEALS/YEAR	78573
TOTAL PATIENT CENSUS	26,191	NET FOOD	120300
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	78573
TOTAL PATIENT MEALS	78573	COST PER MEAL	1.53
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN #0041889 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			26,122	26,122		26,122	12,930	39,052			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,010	27,010		27,010		27,010			32
33	Real Estate Taxes			42,833	42,833		42,833		42,833			33
34	Rent-Facility & Grounds			75,000	75,000		75,000	3,426	78,426			34
35	Rent-Equipment & Vehicles			19,557	19,557		19,557		19,557			35
36	Other (specify):* storage			1,020	1,020		1,020		1,020			36
37	TOTAL Ownership			191,542	191,542		191,542	16,356	207,898			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		53,052	125,870	178,922		178,922		178,922			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,605	64,605		64,605		64,605			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		53,052	190,475	243,527		243,527		243,527			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,386,716	317,298	1,416,866	3,120,880		3,120,880	(75,042)	3,045,838			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	11,082	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(268)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(12,838)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(3,673)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,732)	20		28
29	Other-Attach Schedule	(55,487)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (62,916)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(12,126)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (12,126)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (75,042)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

CARE CENTRE OF CHAMPAIGN

ID# 0041889

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2	LEGAL FEES	(27,968)	19	2
3	MARKETING	(27,519)	27	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(55,487)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN **#** 0041889 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(268)	0	0	0	0	0	0	0	0	0	0	(268)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	476	0	0	0	0	0	0	0	0	476	5
6	Maintenance	0	0	312	0	0	0	0	0	0	0	0	312	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(268)	0	788	0	0	0	0	0	0	0	0	520	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	19,605	0	0	0	0	0	0	0	0	19,605	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	19,605	0	0	0	0	0	0	0	0	19,605	16
	C. General Administration													
17	Administrative	0	(23,911)	27,132	0	0	0	0	0	0	0	0	3,221	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(27,968)	(47,748)	3,193	0	0	0	0	0	0	0	0	(72,523)	19
20	Fees, Subscriptions & Promotions	(5,405)	0	47	0	0	0	0	0	0	0	0	(5,358)	20
21	Clerical & General Office Expenses	(12,838)	(107,496)	77,954	0	0	0	0	0	0	0	0	(42,380)	21
22	Employee Benefits & Payroll Taxes	0	0	9,751	0	0	0	0	0	0	0	0	9,751	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	6,737	0	0	0	0	0	0	0	0	6,737	24
25	Other Admin. Staff Transportation	0	0	6,172	0	0	0	0	0	0	0	0	6,172	25
26	Insurance-Prop.Liab.Malpractice	0	0	10,376	0	0	0	0	0	0	0	0	10,376	26
27	Other (specify):*	(27,519)	0	0	0	0	0	0	0	0	0	0	(27,519)	27
28	**TOTAL General Administration**	(73,730)	(179,155)	141,362	0	0	0	0	0	0	0	0	(111,523)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(73,998)	(179,155)	161,755	0	0	0	0	0	0	0	0	(91,398)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	11,082	0	1,848	0	0	0	0	0	0	0	0	12,930	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	3,426	0	0	0	0	0	0	0	0	3,426	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	11,082	0	5,274	0	0	0	0	0	0	0	0	16,356	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(62,916)	(179,155)	167,029	0	0	0	0	0	0	0	0	(75,042)	45

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		CERTIFIED HEALTH MANAGEMENT	SKOKIE	BKKPG/MGMT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 23,911			$	$ (23,911)	1
2	V	21	BOOKKEEPING	107,496				(107,496)	2
3	V	19	ADMIN CONSULTING FEES	47,748				(47,748)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 179,155			$	$ * (179,155)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	CERTIFIED HEALTH MANAGEMENT		$ 0	$	15
16	V	5	ELECTRIC/GAS		" " "		476	476	16
17	V	6	MAINTENANCE		" " "		312	312	17
18	V	10	NURSING/MEDICAL RECORDS		" " "		19,605	19,605	18
19	V	17	ADMIN SALARIES		" " "		27,132	27,132	19
20	V	19	PROFESSIONAL FEES		" " "		3,193	3,193	20
21	V	20	FEES, SUBSCRIPTION		" " "		47	47	21
22	V	21	OFFICE EXP		" " "		77,954	77,954	22
23	V	22	EMPLOYEE BENEFITS		" " "		9,751	9,751	23
24	V	24	TRAVEL.SEMINAR		" " "		6,737	6,737	24
25	V	25	TRANSPORTATION		" " "		6,172	6,172	25
26	V	26	INSURANCE		" " "		10,376	10,376	26
27	V	30	DEPRECIATION		" " "		1,848	1,848	27
28	V	32	INTEREST		" " "		0		28
29	V	34	OFFICE RENT		" " "		3,426	3,426	29
30	V	35	EQUIPMENT RENTAL		" " "		0		30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 167,029	$ * 167,029	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	BRADLEY ALTER		ADMINISTRATION		SEE ATTACHED SCHEDULE			SALARY	$ 20,487	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 20,487		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CERTIFIED HEALTH MANAGEMENT
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 674-4700
Fax Number: ((847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	246,749	8	$ 0	$	23,479	$ 0	1
2	5	ELECTRIC & GAS	" " "	246,749	8	5,007		23,479	476	2
3	6	MAINTENANCE	" " "	246,749	8	3,275		23,479	312	3
4	10	NURSING/MEDICAL RECORDS	" " "	246,749	8	206,038	206,038	23,479	19,605	4
5	17	ADMIN SALARIES	" " "	246,749	8	285,136	285,136	23,479	27,132	5
6	19	PROFESSIONAL FEES	" " "	246,749	8	33,552		23,479	3,193	6
7	20	FEE, SUBSCRIPTIONS	" " "	246,749	8	490		23,479	47	7
8	21	OFFICE EXP.	" " "	246,749	8	819,245	705,623	23,479	77,954	8
9	22	EMPLOYEE BENEFITS	" " "	246,749	8	102,474		23,479	9,751	9
10	24	TRAVEL/SEMINAR	" " "	246,749	8	70,798		23,479	6,737	10
11	25	TRANSPORTATION	" " "	246,749	8	64,859		23,479	6,172	11
12	26	INSURANCE	" " "	246,749	8	109,041		23,479	10,376	12
13	30	DEPRECIATION	" " "	246,749	8	19,425		23,479	1,848	13
14	32	INTEREST	" " "	246,749	8	0		23,479	0	14
15	34	OFFICE RENT	" " "	246,749	8	36,000		23,479	3,426	15
16	35	EQUIPMENT RENTAL	" " "	246,749	8	0		23,479	0	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,755,340	$ 1,196,797		$ 167,029	25

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANKFINANCIAL		X	working capital line of credit							25,778	6
7	AICCO		X	ins. Financing							1,232	7
8												8
9	TOTAL Facility Related						$	$			$ 27,010	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 27,010	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 40,625	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 41,316	2
3. Under or (over) accrual (line 2 minus line 1).		$ 691	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 42,142	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 42,833	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	37,086	8
	2001	37,948	9
	2002	39,229	10
	2003	39,828	11
	2004	41,316	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CARE CENTRE OF CHAMPAIGN COUNTY CHAMPAIGN

FACILITY IDPH LICENSE NUMBER 0041889

CONTACT PERSON REGARDING THIS REPORT DON FIETS

TELEPHONE (847) 674-4700 FAX #: (847) 674-4733

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	45-20-22-282-005	NURSING HOME	$ 41,315.90	$ 41,315.90
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 41,315.90	$ 41,315.90

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,000 B. General Construction Type: Exterior CONCRETE Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOFING			1996	9,253	237	39	237	0	2,222	9
10	SIDEWALK & PATIO			1996	4,146	276	15	276	0	2,557	10
11	DOOR INSTALLED			1996	636	16	39	16	0	146	11
12	HANDRAIL &BUMPER GUARD			1997	2,620	67	39	67	0	544	12
13	FLOOR TILES & CARPETS			1997	19,732	506	39	506	(0)	4,069	13
14	FLOORING, WALLPAPER, CEILING REPAIR			1998	13,669	350	39	350	0	2,745	14
15	ELECTRICAL WORK			1998	7,500	192	39	192	0	1,464	15
16	LANDACAPING			1998	11,551	770	15	770	0	5,775	16
17	DRYWALL/CEILING REPAIR			1999	3,860	99	39	99	(0)	681	17
18	ROOF REPAIR			1999	3,109	80	39	80	(0)	537	18
19	SIDEWALK REPAIR			1999	4,023	268	15	268	0	1,742	19
20	ROOF REPAIR			2000	10,000	364	27.5	364	(0)	2,108	20
21	WALLPAPER			2000	2,440	349	7	349	(0)	2,343	21
22	WALL/CEILING REPAIR			2000	1,425	52	27.5	52	(0)	292	22
23	CURCUIT BREAKERS			2000	710	26	27.5	26	(0)	130	23
24	WALLPAPER/HANDRAILS			2001	7,050	256	27.5	256	0	1,152	24
25	FLOOR TILE			2001	1,711	62	27.5	62	0	279	25
26	FLOOR BASE/WALLPAPER			2001	1,446	53	27.5	53	(0)	238	26
27	KICKPLATES			2001	995	36	27.5	36	0	162	27
28	HVAC UNIT			2001	3,162	115	27.5	115	(0)	487	28
29	ROOF REPLACEMENT-PARTIAL			2002	25,450	925	27.5	925	0	3,238	29
30	DOME ROOF REPAIR			2002	6,750	245	27.5	245	0	858	30
31	ENTRANCE DOORS			2002	4,193	152	27.5	152	0	532	31
32	LINTEL REPLACEMENT-OUTSIDE			2002	7,500	273	27.5	273	(0)	955	32
33	LINTEL REPLACEMENT-INSIDE			2002	1,800	69	27.5	65	(4)	228	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BLINDS DINING ROOM/HALLWAYS	2003	$ 6,370	$ 1,452	5	$ 1,274	$ (178)	$ 3,185	37
38	ROOF REPLACEMENT	2003	35,900	1,305	27.5	1,305	0	3,263	38
39	DRYWALL REPLACEMENT RES ROOMS	2003	2,650	96	27.5	96	0	240	39
40	ALARM SYSTEM	2003	1,895	69	27.5	69	(0)	172	40
41	FLOORING	2003	7,859	286	27.5	286	(0)	715	41
42	DINING ROOM TABLES/CHAIRS	2003	17,537	638	27.5	638	(0)	1,595	42
43	KITCHEN FLOORING	2003	1,358	49	27.5	49	0	123	43
44	ALARM SYSTEM	2003	1,605	58	27.5	58	0	145	44
45	GREASETRAP IN KITCHEN FLOOR	2003	2,850	104	27.5	104	(0)	260	45
46	WALL AIR CONDITIONERS	2003	1,833	67	27.5	67	(0)	167	46
47	ALARM SYSTEM	2003	2,698	98	27.5	98	0	245	47
48	ASPHALT RESURFACING	2004	6,750	450	15	450		675	48
49	TILE	2004	4,214	153	27.5	153		230	49
50	ROOF REPAIRS	2004	3,200	116	27.5	116		174	50
51	FLOOR TILE TESTING/REMOVAL	2004	5,500	200	27.5	200		300	51
52	WATER MAIN WORK	2004	800	29	27.5	29		44	52
53	FIRE LINE FOR SPRINKLER	2004	9,975	363	27.5	363		544	53
54	CEILING REMOVAL/REPLACEMENT	2004	3,810	139	27.5	139		208	54
55	EXTERIOR EMERG. LIGHT	2004	827	30	27.5	30		45	55
56	SPRINKLER SYSTEM	2004	7,357	268	27.5	268		402	56
57	CEILING/WALL REPLACEMENT	2005	4,620	133	27.5	84	(49)	84	57
58	SPRINKLER SYSTEM	2005	50,000	1,288	27.5	909	(379)	909	58
59	LANDSCAPING	2005	10,800	246	27.5	196	(50)	196	59
60	ROOFTOP COMPRESSORS	2005	5,526	154	15	184	30	184	60
61	ROOF REPAIR/REPLACEMENT	2005	21,450	98	27.5	390	292	390	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 372,115	$ 13,727		$ 13,392	$ (334)	$ 49,982	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 139,565	$ 11,293	$ 23,261	$ 11,968	5-7YEARS	$ 94,570	71
72	Current Year Purchases	5,513	1,103	551	(552)	5 YRS	551	72
73	Fully Depreciated Assets	9,967					9,967	73
74			1,848	1,848				74
75	TOTALS	$ 155,045	$ 14,244	$ 25,660	$ 11,416		$ 105,088	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 527,160	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 27,971	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 39,052	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 11,082	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 155,070	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: $ 19,557 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 52,102	$		$ 52,102	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			12,053			12,053	2
3	Licensed Recreational Therapist	39-3	hrs							3
4	Licensed Physical Therapist	39-3	hrs			61,715			61,715	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				48,379		48,379	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES & Other (specify): LABORATORY	39-2					4,673		4,673	13
14	TOTAL			$		$ 125,870	$ 53,052		$ 178,922	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 106,815)	828,459		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,345		6
7	Other Prepaid Expenses	12,245		7
8	Accounts Receivable (owners or related parties)	142,125		8
9	Other(specify): real estate tax escrow	19,213		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,038,387	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	372,114		15
16	Equipment, at Historical Cost	158,253		16
17	Accumulated Depreciation (book methods)	(194,067)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): option deposit	345,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 681,300	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,719,687	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 486,343	$	26
27	Officer's Accounts Payable	744,000		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	495,609		29
30	Accrued Salaries Payable	14,604		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,238		31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,142		32
33	Accrued Interest Payable	242,866		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,035,802	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	capital stock	10,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 10,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,045,802	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (326,115)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,719,687	$	48

***(See instructions.)**

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN **#** 0041889 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (321,354)	1
2	Restatements (describe):		2
3	correct beginning balance	32,780	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (288,574)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(37,541)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (37,541)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (326,115)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,879,211	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,879,211	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	173,307	6
7	Oxygen	29,456	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 202,763	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	1,365	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,365	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,083,339	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	562,451	31
32	Health Care	1,286,671	32
33	General Administration	836,689	33
	B. Capital Expense		
34	Ownership	191,542	34
	C. Ancillary Expense		
35	Special Cost Centers	178,922	35
36	Provider Participation Fee	64,605	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,120,880	40
41	**Income before Income Taxes (line 30 minus line 40)****	(37,541)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (37,541)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,854	1,950	$ 51,172	$ 26.24	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,682	8,908	209,874	23.56	3
4	Licensed Practical Nurses	2,185	2,274	44,333	19.50	4
5	CNAs & Orderlies	40,813	41,267	486,555	11.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	695	893	18,066	20.23	8
9	Activity Director	2,293	2,506	26,864	10.72	9
10	Activity Assistants	2,211	2,350	15,581	6.63	10
11	Social Service Workers	1,666	1,969	22,037	11.19	11
12	Dietician					12
13	Food Service Supervisor	1,736	1,760	28,078	15.95	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,279	7,597	71,708	9.44	15
16	Dishwashers	3,993	4,083	31,063	7.61	16
17	Maintenance Workers	2,009	2,249	32,531	14.46	17
18	Housekeepers	9,879	10,265	74,772	7.28	18
19	Laundry	5,181	5,666	42,149	7.44	19
20	Administrator	2,024	2,080	57,234	27.52	20
21	Assistant Administrator	1,992	2,080	36,563	17.58	21
22	Other Administrative					22
23	Office Manager	2,110	2,379	40,044	16.83	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,952	2,140	25,850	12.08	31
32	Other Health C: care plan coord			44,723		32
33	Other(specify) marketing	1,726	1,760	27,519	15.64	33
34	TOTAL (lines 1 - 33)	100,280	104,176	$ 1,386,716 *	$ 13.31	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	120	$ 5,858	1-3	35
36	Medical Director	750/month	9,000	9-3	36
37	Medical Records Consultant	50	2,025	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		0	10-3	39
40	Physical Therapy Consultant		19	10a-3	40
41	Occupational Therapy Consultant		29	10a-3	41
42	Respiratory Therapy Consultant		42	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	40	1,600	11-3	44
45	Social Service Consultant	75	2,623	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	285	$ 21,196		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	505	$ 24,255	10-3	50
51	Licensed Practical Nurses	5,342	208,434	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)	5,847	$ 232,689		53

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
GARY COULTER	ADMIN		$ 42,096
BRENDA DIVELY	ASST ADMIN		36,563
KATHY PICKERING	ADMIN		15,138
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 93,797

B. Administrative - Other

Description	Amount
CERTIFIED HEALTH MGMT	$ 23,911
TOTAL (agree to Schedule V, line 17, col. 3)	$ 23,911
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		98,498
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 98,498

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 65,542
Unemployment Compensation Insurance		54,175
FICA Taxes		105,098
Employee Health Insurance		56,054
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		1,618
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		2,353
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
MGMT CO ALLOCATION		9,751
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 294,591

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,080
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	5,405
TRUST/FRANCHISE/CONTRIB/ETC	0
LICENSES & PERMITS	3,010
DUES & SUBSCRIPTIONS	448
MGMT CO ALLOCATION	47
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(3,673)
Yellow page advertising	(1,732)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,585

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	131
Seminar Expense	
	509
MGMT CO ALLOCATION	6,737
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,377

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
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18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **64,605**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees